

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8722
Registrar's No. 2205

Registration District No. 7914

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. John's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Joseph H. Niggemann
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mathilde Niggemann 6. (c) Age of husband or wife if alive UNK. years
7. Birth date of deceased 19 Nov 15, 1877 (Month) (Day) (Year)

8. AGE: Years 62 Months 3 Days 18 If less than one day hr. _____ min. _____

9. Birthplace St. Louis, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Mechanic

11. Industry or business _____

MOTHER FATHER { 12. Name Joseph Niggemann
13. Birthplace Germany (City, town, or county) (State or foreign country)
14. Maiden name Max Mueller
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mathilde Niggemann
(b) Address 4955 Blow St

17. (a) Burial (b) Date thereof 3-7-40 (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter + Paul

18. (a) Signature of funeral director Southern Funeral Home

(b) Address 6322 S. Grand

19. (a) MAR 5 1940 (b) _____ (Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis 2
(If outside city or town limits, write "RURAL")
(d) Street No. 4955 Blow St (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 4th year 1940 hour _____ minute 6 a. M.

21. I hereby certify that I attended the deceased from 2-13-40 to 3-4-40, 1940
that I last saw him alive on 3-3, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis

Due to Arterio Sclerosis

Due to if 1/10

Other conditions (Include pregnancy within 3 months of death) if 1/10

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (b) Means of injury _____

23. Signature Carl J. Harris (M. D. or other) _____
Address 3604 Washington Date signed 3-5-40

Dr. O. P. J. Falk
11-2
3604 Washington

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____,
_____, Registered Apprentice No. _____,
working under my personal supervision.

Signed _____

Virgil L. Berryman

Licensed Embalmer No. *4018*

P. O. Address *St. Louis Mo.*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.